TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-020
2. STATE: Iowa
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $ 0
b. FFY 03 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 1 & 2, 7 & 8, 12, 14 & 15. 18, 23, 26, 28a, & 31

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 1 & 2, 7 & 8, 12, 14 & 15, 18, 23, 26, 26a, & 31

10. SUBJECT OF AMENDMENT:
Payment rate changes; makes changes to historical data and cost reporting time periods used for rebasing of base and capital costs and the recalibration of DRG weights; clarifies requirements of the PRO in reviewing outlier cases; and updates a federal regulation citation.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Diane L. Kamm

13. TYPED NAME:

14. TITLE:

15. DATE SUBMITTED:
9-11-02

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/17/02
18. DATE APPROVED: 12/13/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/1/02
20. SIGNATURE OF REGIONAL OFFICIAL: Brenda Smith
21. TYPED NAME: CHARLENE BROWN
22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

1. Introduction

Medicaid reimbursement for inpatient hospital care is based on payment according to diagnosis-related groups (DRG). These rates are rebased and the DRG weights are recalibrated once every three years. Hospitals receiving reimbursement as critical access hospitals are not subject to rebasing.

This state plan reflects the rebasing and recalibration implemented October 1, 2002. The current DRG payment is established through a base-year rate (2001) to which an annual legislative index may be applied on July 1 of each year.

The reimbursement amount is a blend of hospital-specific and statewide average costs reported by each hospital, for the routine and ancillary base and capital cost components, per Medicaid discharge.

Direct medical education, indirect medical education, and disproportionate share payments are made directly from the Graduate Medical Education and Disproportionate Share Fund. They are not added to the reimbursement for claims.

2. Definitions

Certain mathematical or technical terms may have a specific meaning used in this context. The following definitions are provided to ensure understanding among all parties.

"Adolescent" means a Medicaid patient 17 years of age or younger.

"Adult" means a Medicaid patient 18 years of age or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base-year cost report" means the hospital's cost report with a fiscal year ending on or after January 1, 2001, and before January 1, 2002. Cost reports shall be reviewed using Medicare cost reporting and cost reimbursement principles for those cost-reporting periods.

For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15).

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Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. Costs are considered to be reasonable when they do not exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Inclusion in the cost report of costs that are not directly related to patient care or are not in accord with Medicare principles of reimbursement is not appropriate. Examples of administrative and general costs that must be related to patient care to be a reportable cost are:

- Advertising
- Promotional items
- Feasibility studies
- Dues, subscriptions or membership costs
- Contributions made to other organizations
- Home office costs
- Public relations items
- Any patient convenience items
- Management fees for administrative services
- Luxury employee benefits (i.e., country club dues)
- Motor vehicles for patient care
- Reorganization costs

"Blended base amount" means the case-mix-adjusted, hospital-specific operating costs per discharge associated with treating Medicaid patients, plus the statewide average, case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which add-on payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals are not used to determine the statewide average, case-mix-adjusted operating cost per Medicaid discharge.

"Blended capital costs" means hospital-specific capital costs, plus statewide average capital costs, divided by two.

"Capital costs" means an add-on to the blended base amount which shall compensate for Medicaid's portion of capital costs. Capital costs for building, fixtures, and movable equipment are defined in the hospital's base-year cost report, are case-mix adjusted, are adjusted to reflect 80% of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

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3. Definition of Allowable Costs

Allowable costs are those defined as allowable in 42 CFR, Part 413, except as specifically excluded or restricted in the state plan.

Costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item. Only those costs are considered in calculating the Medicaid inpatient reimbursable cost per discharge for the purpose of this plan.

4. Explanation of the Cost and Rate Calculations

The base-year allowable costs used for determining the hospital-specific cost per discharge and the statewide average cost per discharge can be determined by using the individual hospital's 2001 Medicare Cost Report (HCFA-2552), Worksheets D-1 and D-4, as submitted to the state.

The total number of Medicaid discharges can be determined from documents labeled PPS-1 and PPS-2, Worksheet S-3 in the report or the MMIS claims documentation system.

a. Calculation of Hospital-Specific and Statewide Net Medicaid Discharges

The total number of Medicaid discharges is determined from the number reported in the cost report or the MMIS claims documentation system. Subtracted from this total number of discharges for each hospital are discharges that have been paid as transfers or short-stay outliers.

This number is known as the net hospital-specific number of discharges. To arrive at the statewide net number of discharges, all net hospital-specific numbers of discharges are summed.

b. Calculation of the Hospital-Specific Case-Mix-Adjusted Average Cost Per Discharge

As determined from the 2001 base-year cost report, the hospital-specific case-mix adjusted average cost per discharge is calculated by starting from:

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The **lower** of total Medicaid costs **or** covered reasonable charges for each Iowa hospital (LOCOC) less 20% of capital expenses
– The remaining 80% of actual costs reported for capital expenditures
– The actual costs reported for direct medical education
– Calculated payments made for non-full DRG transfers
– Calculated payments made for outliers
– Payment made for physical rehabilitation (if included)
= **Net allowable base costs or charges**

The net allowable base costs or charges amount is then inflated, case-mix-adjusted and divided by the net number of hospital-specific Medicaid discharges to obtain the hospital-specific case-mix-adjusted cost per discharge, as shown:

Net allowable base costs or charges
× Hospital inflation update factor
= Inflated net allowable base cost
÷ Hospital-specific case-mix index
= Inflated, case-mix-adjusted net allowable base costs or charges
÷ Net hospital-specific Medicaid discharges (less non-full DRG transfers and short stay outliers)
= **Hospital-specific case-mix-adjusted cost per discharge.**

c. Calculation of the Statewide Average Case-Mix-Adjusted Cost per Discharge

The statewide average case-mix-adjusted cost per discharge is calculated from:

The **LOCOC figures** for each Iowa hospital, except those receiving reimbursement as critical access hospitals, less 20% of actual capital costs as reported
– The remaining 80% of hospital-specific capital costs
– Hospital-specific direct medical education costs
– All hospital-specific payments for transfers
– All hospital-specific payment for outliers
– All hospital-specific payments for physical rehabilitation (if included in above)
– All hospital-specific payments for indirect medical education
= **Hospital-specific net base cost for statewide average**

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9. Trending Reimbursement Rates Forward

The base-year cost for the current rebasing is the hospital's 2001 fiscal year end. A hospital's assigned rate is the 2001 base-year rate that is case-mix-adjusted for each succeeding year. The only adjustments made to this rate are for fraud, abuse, and material changes brought about by cost report reopenings done by Medicare or Medicaid.

The rates have been trended forward using inflation indices of 2.8% for SFY 1998, 0.0% for SFY 1999, 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, and 0.0% for SFY 2003. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

10. Ceilings and Upper Limit Requirements

Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost. This principle is not altered by the DRG reimbursement methodology.

At the end of the cost reporting period, the aggregate covered charges for the period are determined and compared to the aggregate payments made to the hospital under the DRG payment methodology (before any subtraction of third-party payments). If the aggregate covered charges are less than the aggregate payments made using the DRG rates, the amount by which payments exceed the covered charges is requested and collected from the hospital.

This adjustment is performed each year at the end of the hospital's fiscal year, and does not have any impact upon the DRG rates that have been calculated for the next year. There is no carryover of unreimbursed costs into future periods under this DRG reimbursement methodology.

In accordance with 42 CFR 447.271, as part of the final settlement process, the fiscal agent of the Department determines each hospital's total inpatient customary charges for all patients and total days for all patients during the cost reporting period. This is converted to an aggregate customary charge per day.

The fiscal agent then determines the total payments for Medicaid as if this aggregate customary charge per day had been used. Final payment for the cost reporting period in question is made to each hospital at a per-day amount not to exceed its aggregate customary charge per day. This test is applied on a hospital by hospital basis.

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11. Explanation of Iowa-Specific Relative Weights

Diagnosis-related groups are categories established by CMS and distributed by 3M. The number of DRGs is determined by CMS, and is updated when needed. A DRG weight is a relative value associated with the charge for treating a particular diagnosis when compared to the cost of treating an average discharge. The recalculation of the Iowa-specific weights is called recalibrating.

Iowa-specific weights have been calculated using applicable claims for the period of January 1, 2000, through December 31, 2001, and paid through March 31, 2002. The recalibrating includes all normal inlier claims, the estimated inlier portion of long-stay outliers, transfer cases where the payment is greater than or equal to the full DRG payment, and the estimated inlier portion of cost-outlier cases. Short-stay outliers and transfer cases where the final payment is less than the full DRG payment are discarded from that group. This group is known as "trimmed claims."

a. Iowa-specific weights are calculated from Medicaid charge data using trimmed claims with discharge and admission dates occurring from January 1, 2000, through December 31, 2001, and paid through March 31, 2002.

   One weight is determined for each DRG except for Medicaid-certified special units, as defined in Section 19. There are multiple weights for the DRGs affected by those Medicaid-certified special units. The weight used for payment corresponds to the certification level of the specific hospital. Weights are determined as follows:

   1. Determine the statewide geometric mean charge for all cases classified in each DRG.

   2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

   3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean charge for all DRGs.

   4. Divide the statewide geometric mean charge for each DRG by the weighted average geometric mean charge for all DRGs to derive the Iowa-specific weight for each DRG.

   5. Normalize the weights so that the average case has a weight of one.

b. The hospital-specific case-mix index is computed by taking each hospital's trimmed claims from the hospital's 2001 specific cost reporting period; summing the assigned DRG weights associated with those claims; and dividing by the total number of Medicaid trimmed claims associated with that specific hospital for that period.

12. Calculation of Hospital-Specific DRG Payment

The final payment rate, as defined in Section 2, is used to determine the final payment made to a hospital. This final payment rate is multiplied by the weight associated with the patient's assigned DRG. The product of the final payment rate times the DRG weight results in the dollar payment made to a hospital.

13. Explanation of Additional or Reduced Payment to a Facility

Additional payment is made for approved cases meeting or exceeding the Medicaid criteria for day and cost outliers for each DRG. For claims with dates of services ending July 1, 1993, and after, 100% of outlier costs are paid to facilities at the time of remittance. Thresholds for the determination of these outliers are computed during the calculation of the Iowa-specific weights and rebasing. Reduced payments are incurred by a facility due to a patient's unusually short length of stay (short-stay outliers).

Long-stay outliers are incurred when a patient's stay exceeds the upper day-limit threshold. This threshold is defined as the greater of 23 days of care or two standard deviations above the average statewide length of stay for a given DRG. Reimbursement for long-stay outliers is calculated at 60% of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long-stay outliers is made at 100% of the calculated amount and is made when the claim is originally filed for DRG payment.

Short-stay outliers are incurred when a patient's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short-stay outliers is 200% of the average daily rate for each day the patient qualifies up to the full DRG payment. Short-stay outlier claims are subject to PRO review and payment denied for inappropriate admissions.

Cases qualify as cost outliers when costs of service in a given case exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost to charge ratios determined in the base-year cost reports.

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15. Recalibration of Iowa-Specific Weights and Recalculation of Base Amounts and Capital Cost Add-ons

Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 2000, through December 31, 2001 and paid through March 31, 2002. The DRG weights are recalibrated every three years, based upon the most complete and current charge information. All hospital base amounts plus the capital cost add-ons are rebased every three years, based upon the most current and complete cost reports available. Hospitals receiving reimbursement as critical access hospitals do not have base amounts rebased.

16. Groupings or Classification of Providers

No special groupings or classifications of providers are established under this reimbursement methodology except state-owned facilities, as described in Section 8, Calculation of Indirect Medical Education Rate.

17. Exceptions or Exemptions to the Rate-Setting Process

Exceptions to the rate-setting process will be made under the following circumstances:

a. New, Expanded or Terminated Services

Hospitals may offer new or expanded services or permanently terminate a service. This may include the purchase of capital assets requiring certificate of need approval.

Hospitals shall submit a budget or other financial and statistical information no later than 180 days before the effective date of the recalculation of the DRG rates. Budgets should be submitted following the completion of a project requiring the certificate of need or Section 1122 approval by the Iowa Department of Public Health according to rules at 641 Iowa Administrative Code, Chapters 201 and 202.

These budgets and related information are subject to desk review and field audit where deemed necessary. Upon completion of the audits, DRG rates may be adjusted as indicated.

Failure of a hospital to submit the required information timely will result in no rate increase associated with these assets or services when rebasing of base amounts and capital cost add-ons is performed. When the hospital files documentation in a timely manner, the new rate will be made effective at the time new rates are established.

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24. Hospital-Based Physician Cost Component

Medicaid reimbursement regulations require split billing of all hospital professional services. The professional component of all such bills must be billed on the HCFA-1500 claim form. In accordance with 42 CFR 415.55 as amended to December 8, 1995, there are certain circumstances when Medicare will allow a facility with an approved teaching program to combine these components when billing for services. If a provider has been approved by Medicare to bill in this manner, Iowa Medicaid also allows the provider to bill in this fashion.

25. Recovery of Overpayments

When it has been determined that an inpatient hospital provider has been overpaid, a notice of overpayment and request for refund is sent to the provider. The notice states that if the provider fails to submit a refund or an acceptable response to the notice within 30 days, the amount of the overpayment will be withheld from weekly payments to the provider.

26. Fixed Rate

New DRG rates are effective beginning October 1, 2002. Effective July 1, 2002, rates for hospital inpatient services will remain the same as the rates in effect on June 30, 2002.

27. Rate Adjustments for Hospital Mergers

When one or more hospitals merge to form a distinctly different legal entity, the base rate plus the capital cost add-on are revised to reflect this new entity. Financial information from the original cost reports and original rate calculations is added together and averaged to form the new rate for that entity.

28. Interim Payment for Long-Stay Patients

Normal DRG reimbursement is made upon the patient's discharge from the hospital. If a patient has an extremely long stay, partial reimbursement to the hospital may be requested. A hospital can request an interim payment if the patient has been hospitalized 120 days and is expected to remain hospitalized for a minimum of an additional 60 days. Payment to the hospital is calculated at the same rate as normal DRG payments.

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f. Distribution to Qualifying Hospitals for Indirect Medical Education

Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 1999, through June 30, 2000, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights will be updated by a three-year period effective for payments from the fund for July of every third year.

g. Qualifying for Disproportionate Share

Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent or when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of:

- 2½ percent, or
- The product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

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For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

Information contained in the hospital's available 2001 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's inpatient Medicaid utilization rate.

Additionally, a qualifying hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

h. Allocation to Fund for Disproportionate Share

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share related to inpatient services for July 1, 2000, through June 30, 2001, is $6,978,925, adjusted by inflation or utilization increases, if applicable.

Methods and Standards for Establishing Payment Rates for Critical Access Hospitals Providing Inpatient Care

A critical access hospital is a hospital that:

- Meets Medicare guidelines established in 42 CFR Part 485, Subpart F, and state hospital licensure requirements established in 481 Iowa Administrative Code 51.52(135B) as a hospital that serves a rural or vulnerable population, and
- Is necessary to the economic health and well being of the surrounding community.

Hospitals applying for critical access status are inspected, licensed, and certified as critical access hospitals, using Medicare criteria, by the Iowa Department of Inspections and Appeals.

Critical access hospital providers are reimbursed prospectively on a diagnosis-related-group basis for inpatient care, pursuant to 441 Iowa Administrative Code 79.1(5), which defines a diagnosis-related-group as a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Retrospective adjustments will be made based on each critical access hospital's annual cost reports submitted to the Department at the end of the hospital's fiscal year. The retroactive adjustment equals the amount by which the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), determined in accordance with Medicare cost principals, exceeds Medicaid fee-for-service reimbursement received on the diagnosis-related-group basis.

The diagnosis-related-group base rate for each critical access hospital will change for the coming year based on payments made to the critical access hospital for the previous year. The base rate upon which the diagnosis-related-group payment is built shall be changed after cost settlement to reflect, as accurately as is possible, the anticipated payment to the facility under Iowa Medicaid for the coming year using the most recent utilization as submitted to the fiscal agent. Once a hospital begins receiving reimbursement as a critical access hospital, diagnosis-related group payments are not subject to rebasing.

MEDICAID STATE PLAN Signoff Sheet

TO: Mike Baldwin,
Medicaid State Plan Coordinator,
Unit of Health Supports

DATE: August 5, 2002

For the attached Medicaid State Plan amendment:

The effective date is: July 1, 2002

Fiscal Impact:

	Federal		
FFY	2002	(current federal fiscal year)	$ 0
FFY	2003	(next federal fiscal year)	$ 0
	State		
SFY	2002	(current state fiscal year)	$ 0
SFY	2003	(next state fiscal year)	$ 0

MS-02-20

Brief summary of Medicaid State Plan amendment (to be used on the transmittal form):
Updates payment rate changes beginning July 1, 2002; Make changes to the historical data and cost reporting time periods used for the rebasing of base and capital costs and the recalibration of DRG weights for inpatient hospital reimbursement. Also, revisions are made to clarify the current requirements of the PRO in reviewing outlier cases, plus an update is provided to a federal regulation citation.

This amendment is:

☐ A federal mandate ☐ A legislative mandate X☐ Optional (explain) Required in state administrative rules; Clean-up.

Signoffs

Program Staff: Patti Becker	
Deputy Director for Policy: CMA	